formation of a nucleus upon which other crystals may grow; and (c) augmentation of the size of already existing stones by being layed down in lamina, patches or encrustations. Most of their patients were taking usual doses of the triamterene–hydrochlorothiazide combination and often had a past history of stone formation. Ettinger and colleagues also suggested that such patients may have reduced ability to convert triamterene to its more soluble metabolites.

Triamterene stones should be considered in patients with nephrolithiasis, and triamterene should not be prescribed for patients with a history of kidney stones.

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Ocular toxocariasis

To the editor: I read with interest the recent review article "Visceral larva migrans (toxocariasis) in Toronto" (*Can Med Assoc J* 1981; 124: 21–26), in which Fanning and colleagues outlined the results of their search for cases of visceral larva migrans documented in the inpatient records of the Hospital for Sick Children in Toronto for the years 1952 through 1978. The authors stated that they found only two possible cases and one doubtful case of ocular toxocariasis, but cases in patients attending outpatient clinics would have been overlooked because of the study design.

Ocular toxocariasis is essentially a disease of the retina, and it often leads to blindness. Ophthalmologists familiar with its ophthalmoscopic appearance can often distinguish the retinal lesions by their characteristic features. Other causes of leukokoria such as endophthalmitis, tumour or intraocular foreign body seldom cause confusion in diagnosis.

Toxocara canis ova are very common in soil samples. In one survey approximately 25% of soil samples obtained throughout Britain were found to contain these ova.[1] In another survey it was found that the stools of more than 43% of stray dogs contained *T. canis* and other parasites.

In Montreal in 1971 a bylaw was passed stipulating that all animals having some infectious endoparasitic or ectoparasitic disease should be isolated and treated without delay.[2] Such a bylaw should probably be instituted in large metropolitan areas and enforced by public health officers, for toxocariasis is a preventable cause of blindness.

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Late local allergic response to insect sting

To the editor: In allergic individuals intracutaneous injection of antigen can lead to the well known immediate wheal and flare. Many individuals also have a late allergic response, which can be a much larger swelling, generally with erythema and itching; it typically reaches a maximum at about 12 hours and disappears after 1 to 2 days.[1]

Insect stings often incite local swelling. The appearance and time course are those of the late allergic response. The history of a sting, the time course and the lack of findings such as pus or a foreign body indicate an allergic rather than infectious basis. An antibiotic is often prescribed unnecessarily. Left alone, the late allergic response evolves predictably and disappears in a few days. In the rare event that there is an urgent need to eliminate the swelling, only an adrenocortical steroid is effective. An adult might take 40 mg of prednisone immediately and then again in 4 hours. Epinephrine is an important drug in the treatment of anaphylaxis but has little effect on a late allergic response.

More than 50% of people with a history of large local reactions to insect stings will have positive responses to allergy skin tests with insect venom.[2,3] In contrast, only about 15% of individuals who have not had unusual reactions to insect stings will have comparable results of skin tests.[2] In people with local reactions the risk of anaphylaxis from a subsequent sting is about 5%, greater than that for the general population.[3] Currently this risk is not taken as sufficient justification for desensitization treatment with venom antigen, which is limited to individuals with a history of anaphylaxis and proven sensitivity. Whole-body extract no longer has a place in the diagnosis or treatment of allergy to insect stings.[4,5]

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